

Jaclynn Spencer D.D.S.
Brighton Smiles, PC
Family Dentistry

Patient Information

Name(Last,First,Middle): _____ Title: _____

Preferred Name: _____ Sex: _____

SS# _____ DOB: _____ Age: _____ Marital: S / M / D / W

Home Address: _____

Phone# _____ Work# _____ Cell# _____

Occupation: _____ Employer: _____

E-Mail: _____ Driver License# _____

Emergency Contact: _____ Phone # _____

Name of Physician: _____ Phone # _____

Pharmacy: _____ Phone # _____

If under 18

Mother _____ DOB: _____

Father _____ DOB: _____

If you are completing this form for another person, what is your relationship to this person? _____

Whom may we thank for referring you to our office? _____

Acknowledgement of receipt of Notice of Privacy Practices

I, _____, have received a copy of this office's Notice of Privacy Practices.

Signature of Patient/Legal Guardian

Date

Jaclynn Spencer D.D.S.
Brighton Smiles, PC
Family Dentistry

PATIENT ACCOUNT INFORMATION

Patient Name: _____

Primary Dental Insurance: _____

Subscriber's Name: _____ Relation to Patient _____

Subscriber's phone# _____

ID or SS# _____ DOB: _____

Subscriber's Employer: _____

Insurance Company's Name: _____ Group# _____

Insurance Phone # _____

Insurance Address: _____

****We will bill your insurance as a benefit to you. Co-payments and percentages will be collected at the time of service. It must be understood that dental insurance is a relationship between you, the insurance company and your employer. We will always recommend the treatment that is best for our patient. This is not always what your insurance company is willing to pay for, nor does having dental insurance guarantee full coverage of all procedures. You, the patient are ultimately responsible for any charges not paid by the insurance company. Accounts over 90 days will be subject to a finance charge. Accounts extended beyond 120 days will be sent to collections. We are here to make you feel comfortable and hopefully all your questions have been answered to the best of our ability.**

Signature of patient or guardian

Date

Jaclynn Spencer D.D.S.
Brighton Smiles, PC
Family Dentistry

Dental Health Information

Please state your reason for seeking dental care at this time: _____

Are you currently experiencing dental pain or discomfort? _____
Where? _____ How long? _____

How long since your last dental visit? _____ How long since your last dental cleaning? _____

On a scale of 1-10, how healthy do you feel your mouth is ? _____

Are you apprehensive about dental treatment? _____

Do your gums bleed? _____ Are your teeth sensitive to hot, cold or sweets? _____

Are you happy with your smile? _____ Do you frequently have dry mouth? _____

Do you have sores or ulcers in your mouth? _____

Do you have ear aches, neck pains or headaches? _____

Do you have clicking, popping or discomfort in your jaw? _____

Do you grind or clench your teeth? _____

Have you had orthodontic treatment? _____

Have you had any periodontal (gum) treatments? _____

Do you have history of mouth breathing, snoring or sleep apnea? _____

Have you had any problems or complications associated with previous dental treatment? _____

Additional Child's History if applicable please circle:

trauma	mouth sores	mouth breather	chapped lip
speech problems	curious tongue	snoring	bed wetting
toss & turn at night	wakes frequently at night	frequent nightmares	grinding
dark circles under eyes	headaches	ear aches	frequent sore throat
pacifier	thumb sucker	allergies	attention problems

Signature of Patient/Parent/Legal Guardian

Date

Jaclynn Spencer D.D.S.

Brighton Smiles, PC

Family Dentistry

Medical Information

Name _____

Today's Blood Pressure _____

Are you in good health? _____

Have you had a serious illness, operation, or been hospitalized in the past? What? _____

Have you had an orthopedic total joint replacement? _____ Date _____ Any complications? _____

Has a physician or previous dentist recommended antibiotics prior to dental treatment? _____

Are you taking Fosamax, Actonel, or Boniva, for osteoporosis, or Paget's DX? _____

Were you treated or are you presently being treated with intravenous bisphosphonates (such as Aredia or Zometa) for bone pain, hypercalcemia, Paget's, Multiple Myeloma, Metastatic cancer? Date _____

Do you have a history of: Artificial heart valve, Previous infective endocarditis, Damaged valves in a heart transplant, Unrepaired cyanotic CHD, Repaired CHD completely in the last 6 months, Repaired CHD with residual defects? _____

Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of heart disease.

Y N Conditions

- ☐ ☐ Anemia
- ☐ ☐ Angina
- ☐ ☐ Abnormal Bleeding
- ☐ ☐ Arthritis
- ☐ ☐ Aids/HIV
- ☐ ☐ Autoimmune Disease
- ☐ ☐ Artificial Bones/Joints
- ☐ ☐ Asthma
- ☐ ☐ Bronchitis
- ☐ ☐ Cancer
- ☐ ☐ Chemotherapy
- ☐ ☐ Diabetes
- ☐ ☐ Epilepsy
- ☐ ☐ Eating Disorder
- ☐ ☐ COPD
- ☐ ☐ Glaucoma

Allergies

- ☐ Local Anesthetic
- ☐ Latex
- ☐ Sedatives
- ☐ Other Food
- ☐ Sulfa Drugs

Y N Conditions

- ☐ ☐ GERD/Heartburn
- ☐ ☐ Heart Attack
- ☐ ☐ Heart Murmur
- ☐ ☐ Heart Problems/Surgery
- ☐ ☐ Hepatitis
- ☐ ☐ High Blood Pressure
- ☐ ☐ High Cholesterol
- ☐ ☐ Kidney Problems
- ☐ ☐ Liver Problems
- ☐ ☐ Mental Health Disorders
- ☐ ☐ Mitral Valve Prolapse
- ☐ ☐ Pacemaker
- ☐ ☐ Pregnant
- ☐ ☐ Radiation Treatment
- ☐ ☐ Rheumatic Fever
- ☐ ☐ Neurological Disorder
- ☐ ☐ Osteoporosis

- ☐ Metals
- ☐ Codeine or Other Narcotics
- ☐ Milk
- ☐ Other Antibiotics

Y N Conditions

- ☐ ☐ Rheumatoid Arthritis
- ☐ ☐ Respiratory Problems
- ☐ ☐ Seasonal Allergies
- ☐ ☐ Sinus Problems
- ☐ ☐ Seizures
- ☐ ☐ Stroke
- ☐ ☐ Systemic Lupus Erythematosus
- ☐ ☐ Tobacco Habit
- ☐ ☐ Thyroid Problems
- ☐ ☐ Tuberculosis
- ☐ ☐ Ulcers

Do you have any disease, condition, or problem not listed above that you think we should know about?

If so, please list all _____

☐ Aspirin

☐ Iodine

☐ Penicillin

☐ Other: _____

Are you taking any prescriptions or over the counter medications?

If so, please list all: _____

Both Dr. and patient are encouraged to discuss any and all relevant patient health concerns prior to treatment. I understand the importance of a truthful health history and I certify that the information given on this form is accurate. I will not hold my dentist or her team responsible for any action they take or do not take because of errors or omissions.

Signature _____ Date _____

The above information is accurate and complete to the best of my knowledge.

Jaclynn Spencer D.D.S.
Brighton Smiles, PC
Family Dentistry

Name: _____
Today's Date: _____

Sleep Disordered Breathing Questionnaire

Do you experience any of these? (check all that apply)

- | | |
|---|---|
| <input type="checkbox"/> Difficulty breathing through your nose | <input type="checkbox"/> Frequent sinus infections |
| <input type="checkbox"/> Nasal congestion on one side of your nose or the other | <input type="checkbox"/> Difficulty sleeping due to snoring |
| <input type="checkbox"/> Congestion that changes from one side to the other | <input type="checkbox"/> Decreased sense of smell |
| <input type="checkbox"/> Sleep Apnea | <input type="checkbox"/> Use of steroid nasal spray |

Section Score: _____

Nights per week snoring and how loud?

- | | |
|--|--|
| <input type="checkbox"/> 2 or less (0 pts) | <input type="checkbox"/> Slightly louder than breathing (0 pts) |
| <input type="checkbox"/> 3 - 4 (2 pts) | <input type="checkbox"/> As loud as talking (2 pts) |
| <input type="checkbox"/> 5 or more (5 pts) | <input type="checkbox"/> Heard through closed doors or walls (5 pts) |

Section Score: _____

Witnessed Apnea or Startled Awakening or Gasping?

- | | | |
|--|--|--|
| <input type="checkbox"/> Never (0 pts) | <input type="checkbox"/> Occasionally (10 pts) | <input type="checkbox"/> Frequently (15 pts) |
|--|--|--|

Section Score: _____

Neck or Collar Size:

- | Male | Female |
|---|---|
| <input type="checkbox"/> Less than 17 in. (0 pts) | <input type="checkbox"/> Less than 16 in. (0 pts) |
| <input type="checkbox"/> 17 in. or greater (15 pts) | <input type="checkbox"/> 16 in. or greater (15 pts) |

Section Score: _____

Sleepiness: How likely are you to doze off?

0 - Never 1 - Slight Chance 2 - Moderate Chance 3 - High Chance

- | |
|--|
| <input type="checkbox"/> Sitting and reading |
| <input type="checkbox"/> Sitting, inactive in a public place (e.g. theatre or meeting) |
| <input type="checkbox"/> As a passenger in a car for an hour without a break |
| <input type="checkbox"/> Lying down to rest in the afternoon when able to do so |
| <input type="checkbox"/> In a car, while stopped for a few minutes in traffic |

Section Score: _____

Other:

- | | |
|--|---|
| <input type="checkbox"/> High Blood Pressure Treated (5 pts) | <input type="checkbox"/> Female (post-menopausal) (5 pts) |
| <input type="checkbox"/> 50 years old or more (1 pt) | <input type="checkbox"/> Male (5 pts) |
| <input type="checkbox"/> Female (pre-menopausal) (0 pts) | |

Section Score: _____

TOTAL SCORE: _____

0 - 17 pts (Low Suspicion of OSA)	= Sleep Study not Recommended
18 - 34 pts (Moderate Suspicion of OSA)	= Nocturnal pulse ox Recommended
35 - 51 pts (Moderate to High Suspicion of OSA)	= Laboratory Sleep Study Recommended
52 - 65 pts (High Suspicion of OSA)	= Laboratory Sleep Study Recommended

Office and Financial Policy

Thank you for choosing Brighton Smiles for your oral health needs. My team and I are committed to provide you with the best possible care. We will be available to discuss our professional fees with you at any time. Your clear understanding of our office and financial policy is important to our professional relationship. Please ask us if you have any questions about our fees, financial policy or your responsibilities.

PAYMENT POLICY: Payment is due at the time services are rendered. For your convenience we accept cash, check, MasterCard and Visa. In special circumstances, extended payment arrangements may be established at your consultation visit. All payment arrangements must be made prior to beginning any treatment. In the event that your account incurs a balance, you are responsible for making timely payments. All balances must be paid in ninety (90) days.

In the event of default, the patient/guardian agrees to pay a reasonable collection agency fee which shall be 35% of the unpaid principal balance. If legal action is initiated, I agree to pay a reasonable collection agency fee, which shall be 40% of the unpaid principal balance and to pay all reasonable court costs and attorney fees as a result of my default. The patient/guardian also agrees to pay interest at the rate of 3% per annum on any account not paid within ninety days. If such action occurs, it is understood that the patient, guardian and family will be unable to continue with the doctor or her auxiliary staff.

INSURANCE: Insurance is a contract between you and your insurance company. Our office will file your claim and attempt to collect payment on your behalf. It is your responsibility to know and understand your dental insurance benefits. You will be expected to pay all estimated patient payments at the time services are rendered. Procedures not covered by your plan and claims not paid within sixty (60) days are your responsibility. Your provider determines the diagnosis as well as the appropriate designation of the type of visit. Some services may not be covered or paid for by your particular insurance benefits, or they may go towards your deductible. Coding for your service will be determined by your dental provider based on the actual services performed and will not be changed to satisfy any insurance limitations. Please contact your insurance plan provider or human resource department for benefit details.

MISSED / CANCELED APPOINTMENTS: Our office policy is to charge for appointments missed or canceled without 48 hours' notice. The charge will range from \$45 and up to the rate of your scheduled appointment. Please help us serve you and all of our patients better by keeping your reserved appointments.

LATE ARRIVALS: If you are 10 minutes or more late to the scheduled appointment time, your appointment may be rescheduled.

CONSENT: The undersigned hereby authorizes Dr. Spencer to take radiographs, study models, photographs or any other diagnostic aids deemed appropriate to make a thorough diagnosis, perform any and all treatments needed, including but not limited to medications, therapy or treatment of the oral cavity. I understand there are risks involved with each and every dental procedure including the administering of anesthetic(s). It is my personal responsibility to request information about treatment so I can make informed decisions regarding my health and dental treatment. Dr. Spencer may choose and employ such assistance as she deems fit. Dr. Spencer may delegate certain tasks to be performed which are legal and ethical by dental assistants and/or hygienists under Colorado dental practice law 12-35-128. Such tasks can be performed with direct or indirect supervision. I understand and consent to the above information regarding treatment, payments, insurance, missed/canceled appointments and late arrivals.

Signature of patient or guardian

Date

-

Date :

Jaclynn Spencer D.D.S.
Brighton Smiles, PC
Family Dentistry

Notice of Privacy Practices

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996, (HIPAA) I understand that by signing this consent I authorize Dr. Jaclynn Spencer's office to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment).
- Obtaining payment from third party payers (my insurance company)
- The day-to-day healthcare operations of Dr. Spencer's practice

I have also been informed of and given the right to review and secure a copy of the Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that Dr. Jaclynn Spencer's office will reserve the right to change the terms of this notice from time to time and that I may contact the office at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used to carry out treatment, payment and health operations; however the office is not required to agree to these requested restrictions. If you agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time.

Signature of patient

Date

Signature of patient or guardian

Relationship to patient